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	155187	A. BUILDING _____ B. WING _____	C 06/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

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F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00149081. This visit resulted in a partially extended survey- Immediate Jeopardy.

Complaint IN00149081-Substantiated. No deficiencies related to the allegations are cited.

Unrelated deficiency cited.

Survey date: June 12, 2014
Extended survey date: June 13, 2014

Facility number: 000098
Provider number: 155187
AIM number: 100290980

Survey team:
Janet Adams, RN-TC

Census bed type:
SNF/NF: 159
Total: 159

Census payor type:
Medicare: 22
Medicaid: 124
Other: 13
Total: 159

Sample: 4
Supplemental Sample: 6

Golden Living Center-Fountainview Place was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint IN00149081.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 000	Continued From page 1 Quality review completed on June 12, 2014, by Janelyn Kulik, RN.	F 000		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure adequate supervision was provided for a resident on a non secured unit who had been displaying exit seeking behaviors and making statements expressing wanting to leave the facility, and the facility not implementing a Physician order to place a Wanderguard (monitoring device) which resulted in the resident being able to exit the facility unsupervised for 1 of 3 residents reviewed related to Wanderguards in the sample of 6. (Resident #F) (LPN #1, LPN #3, and RN#2) This deficient practice had the potential to affect 21 residents who had been identified as having Wanderguards in place for being at risk for elopement. The Immediate Jeopardy began on 5/17/14 when Resident #F was observed with exit seeking behaviors and Physician ordered intervention for a Wanderguard was not implemented and the resident exited the facility unsupervised on	F 323	Past noncompliance: no plan of correction required.	

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5/18/14. The facility Administrator and Director of Nursing were notified of the Immediate Jeopardy on 6/12/14 at 5:39 p.m. The Immediate Jeopardy was removed, and the deficient practice corrected on May 23, 2014, prior to the start of the survey and was therefore Past Noncompliance.

Findings include:

The record for Resident #F was reviewed on 6/12/14 at 1:00 p.m. The resident was admitted to the facility on 5/17/14 at 2:45 p.m. The resident was admitted from the hospital. The resident's diagnoses included, but were not limited to, dementia with behaviors, osteoarthrosis, high blood pressure, cardiac pacemaker, and congestive heart failure.

An Admission Clinical Health Status form was completed on 5/17/14 at 2:45 p.m. The form indicated the resident had a history of wandering. A Fall Risk completed on the form indicated the resident had intermittent confusion. The Risk for Elopement section of the Clinical Health Status form consisted of (8) questions for staff to complete by answering "yes" or "no" to each question.
The following questions were answered "yes."
1. "Is the resident physically able to leave the building on their own?" If no, disregard remaining questions.
3. "Does the resident have impaired decision making skills?"
4. "Does the resident make repetitive statements about going home? If yes, implement Elopement IPOC (Immediate Plan of Care).
6. "Experience a recent move in room or facility?"

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7. "Wanders aimlessly about the facility and/or exhibits night wandering?"

The following questions were answered "no."
2. "Is the resident cognitively impaired? If 1 & 2 are answered yes, proceed to questions 3-8."
5. "Is there a history of wandering or elopement? if yes, implement Elopement IPOC."
8. "Has a recent change in medication?"

The above form also indicated if "Yes" is marked for #1 & #2 and any other (#3-8) consider a prevention plan of care for elopement.

The 5/2014 Physician orders were reviewed. An order was written on 5/17/14 at 3:40 p.m. for the Resident to wear a Wanderguard at all times.

Review of the residents Care Plans indicated there was no Immediate Plan of Care initiated related to elopement risk. A Care Plan indicated the resident was at risk for elopement related to cognition, poor decision making, and delusional thinking. The Care Plan goal was for the resident not to leave the building unattended. This care plan goal was initiated on 5/18/14. There was a care plan intervention in place to test the Wanderguard alarm to make sure it was working correctly. This intervention was dated as initiated on 5/18/14.

Review of the 5/23/14 Minimum Data Set (MDS) Admission assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (5). A score of (5) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident was able to walk in his room and the corridor with only

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supervision. The assessment also indicated "wandering" occurred daily during the assessment reference period.

The 5/2014 Nursing Progress Notes were reviewed. An entry made on 5/17/14 at 8:11 P.M. indicated "Approximately at or around 2:45 p.m. on this date of May 17, 2014 resident arrived via (name of company) ambulance service to facility". The entry also stated the resident was to have a Wanderguard on at all times due to risk of elopement. At or around 4:00 p.m. the resident began becoming agitated and asking about family members. The resident asked "Where is my son?" and "Will you help me to get out of here because I am not gonna stay in this place?" The writer called the resident's son and left a voicemail. The resident continued to ask questions and became eager with staff until his son and wife arrived to visit. The resident asked the son "Why won't you take me home?" and "Are you going to leave without me?" After the son and the wife attempted to leave the resident attempted to leave also and after several redirecting attempts staff was able to relax the resident and provide entertainment on the unit and snacks. At or around 7:30 p.m. the resident was in bed, peaceful, and continued to rest. The above entry was made by LPN #1.

An entry made on 5/18/14 at 1:00 a.m., indicated the resident was up wandering in the halls, was very confused, and said he was trying to find his home. The resident was taken back to his room and assisted to bed. This entry was made by LPN #3.

An entry made on 5/18/14 at 1:40 a.m., indicated the resident was ambulating in the halls, yelling

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out, and knocking on other resident's doors. The resident was assisted to ACU (a locked unit adjoining to the unit the resident resided on). The resident was given a sandwich and milk and was up smiling and ambulating in the halls. The resident informed the writer "that his brain does not work well anymore and that he forgets a lot." This entry was made by LPN #3.

An entry made on 5/18/14 at 3:05 a.m., indicated the resident stated he was tired and was taken back to the Rehab unit (the unlocked unit he had been admitted to) and assisted into bed. The doors on the unit were then closed per nursing judgment as extra precautions. This entry was made by LPN #3.

A Change of Condition entry dated as a "late entry" on 5/18/14 at 3:42 p.m. indicated at approximately 9:40 a.m. the writer had noticed the resident attempting to open the back door on the Rehab unit and the resident was noted to not have a Wanderguard device in place. The House Supervisor was notified, who at that time went to the Social Service office to obtain a device. The writer attempted to offer the resident a newspaper and coffee, the resident accepted, was smiling and standing in the Rehab unit hallway with a CNA. The writer went into another room to provide care to another resident and upon exiting that room, the writer was unable to locate Resident #F after searching throughout the facility. A Code Pink was called per protocol. At approximately 10:06 a.m., a Nurse from another unit came to the writer and stated the (name of city) Police Department was on the telephone and asked if the facility had a missing resident as they had a man in their custody. The staff went to meet with the Police officers in the facility back

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parking lot, the staff identified Resident #F, and the Police entered the facility with the resident. A head to toe assessment was completed and no visible injuries were noted. The Resident continued to state "I want to leave and get out of here." A Wanderguard was placed on the resident's right wrist at this time.

The facility Administrator and Director of Nursing were interviewed on 6/12/14 at 2:10 p.m. The Administrator indicated the resident had been a resident at the facility another time in the past and had no exit seeking behaviors during his previous stay at the facility.

The Director of Nursing indicated the resident had been discharged in January 2014 and was currently admitted to the facility on 5/17/14. The Director of Nursing indicated after the elopement event she interviewed LPN #1 who was the Nurse that admitted Resident #F on 5/17/14. LPN #1 indicated she had made a call on 5/17/14 to the On-Call Nurse related to the resident's behaviors and the need for a Wanderguard device. LPN #1 indicated the On-Call Nurse (RN#2) informed her she would bring one down. LPN #1 also indicated she expected the RN to bring the Wanderguard down to the unit and did not take any further actions to get a Wanderguard at the time. The Director of Nursing indicated the On-Call Nurse was in the facility on 5/17/14 and 5/18/14. The Director of Nursing indicated the On-Call Nurse was interviewed and at one time the Nurse indicated she was not in the building when she spoke to LPN#1. The Director of Nursing indicated the statements were conflicting as LPN #1 had stated the On-Call Nurse who was the Director of Clinical Education (RN#2) had informed her she was in the building and would

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bring it right down. The Director of Nursing indicated RN#2's time card indicated she was punched in at the time LPN #1 called her. RN #2 did not punch out until 7:00 p.m. on 5/17/14. The Director of Nursing indicated RN#2 indicated she did not recall the time she was in the building. The Director of Nursing indicated they interviewed RN #2 on Sunday 5/18/14.

The Director of Nursing also indicated CNA #3 was the CNA the resident was left with on 5/18/14 when LPN #2 entered another resident's room to provide care per the entry in the 5/18/14 Nursing Progress Notes. The CNA indicated she initially was with the resident in the TV room and no one heard any alarms go off.

The Director of Nursing indicated extra Wanderguards were always kept in the Social Service Office. The Director of Nursing indicated the key to the Social Service office was kept on Unit (number of one of the units) and could have been accessed at any time to obtain a Wanderguard. The Director of Nursing indicated the Wanderguard could have been obtained and placed on the resident on 5/17/14 at the time of the Physician's order. The Director of Nursing indicated in their investigation they concluded it was approximately (9) minutes the resident was out based on the time the CNA said she saw the resident last and the time the Police call was made.

The facility Administrator indicated RN #2 was interviewed and the RN did confirm that she received a call from LPN #1 requesting a Wanderguard on 5/17/14. The Administrator also indicated RN#2 was also in the building on the day shift on 5/18/14 and did not apply a

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Wanderguard the morning of 5/18/14 before Resident #F exited the facility. The Administrator stated staff education and discipline were given to RN#2, LPN #1, and LPN #3(LPN who worked the night shift 5/17/14 into 5/18/14). The Administrator indicated a Wanderguard device was placed on the resident when he returned to the building, the resident was moved to the ACU (secured) unit, and the code on the doors were changed as staff and some visitors had the codes to enter one of the doors from the outside and they believe this could have been one of the door the resident exited from.

The facility Administrator and the Director of Nursing were interviewed on 6/12/14 at 2:30 p.m. also. The Administrator indicated after the resident was returned to the facility an investigation was started and interventions were put into place. The punch in codes on the doors were changed to ensure visitors would not be able to enter the door they felt the resident could have been let out of. Education and disciplinary actions were given to RN #2, LPN #1, and LPN #3, the resident was moved to the secured unit, and a Wanderguard was applied. The Director of Nursing indicated a system was put into place for all Nurses to notify the Weekend Manager of new admits and then the Director of Nursing would be called to ensure orders and risks were reviewed at the time of admission. Staff nurses were inserviced on completing IPOC's, the facility Wandering and Elopement protocols on 5/23/14. Orders were checked to verify for orders for Wanderguards and that the Wanderguards had been in place as ordered. All new admission records from 5/17/14 to current were reviewed on 5/19/14 to verify elopement risk and will continue to be review on a daily basis.

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The facility exits were observed with the facility Administrator on 6/12/14. The Administrator identified two exits that they thought Resident #F could have exited from. Outside of these exits there was a large grassy field. The Administrator indicated the resident was found on the grassy field and he estimated the field to be approximately 100 yards. There was a street at the end of the field.

The facility policy titled "Elopement Guidelines" was reviewed on 6/12/14 at 3:30 p.m. There was a revised date of 2013 on the policy. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated each resident was reviewed upon admission to establish elopement risk using the Clinical Health Status form. The policy also indicated the family may be interviewed for previous history of elopement. The responses are to be recorded in the resident's medical record. The policy indicated documentation was to include an Admission assessment which may indicated a potential to wander or exit the facility, a care plan that addressed the potential to wander or exit the facility and measures taken to prevent wandering/elopement. The policy also indicated all new employees were to be inserviced on the Elopement Policy during orientation and all employees were to be inserviced on elopement procedures annually.

The Past Noncompliance Immediate Jeopardy began on 5/17/14. The Immediate Jeopardy was removed and the deficient practice corrected by 5/23/14 after the facility implemented a systemic plan of correction that included the following actions:

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The facility had completed inservicing on 5/23/14 related to the facility Elopement Plan, testing of Wanderguard placement and functioning, testing of door alarms, prevention of elopement, obtaining photos of residents at risk upon admission to be placed in the Medication Administration Records, and the Code Pink called for missing residents to all staff nurses. The inservicing also included, the procedure for obtaining and applying Wanderguards at the time they were ordered or assessed at being needed, post elopement procedures, post elopement resident assessments and the reporting processes. The involved employees were disciplined and educated related to the failure to apply the Wanderguard for Resident #F on 5/17/14 and 5/18/14. The facility had implemented a system for Weekend Managers or the Director of Nursing to review each new weekend admission or re-admission on the day they were admitted to ensure interventions were put into place upon admission for residents identified as elopement risks . All facility doors were assessed to ensure alarms were functioning properly on 5/18/14. All residents who had been admitted 5/17/14 to 5/19/14 were assessed for elopement risk to ensure interventions were in place as needed. All residents at risk for elopement were assessed and wanderguards were checked to ensure proper functioning.

Random staff interviews were completed on 6/13/14 to ensure staff had knowledge of the current policies & procedures related to Elopement and Code Pink events. Facility staff were also interviewed to ensure knowledge of the processes to follow after any resident was identified at risk for elopement and the location of and application of Wanderguards. Residents

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F 323	Continued From page 11 admitted after 5/23/14 records were reviewed and residents were observed to ensure elopement risk assessments had been completed and interventions were in place as needed. The correction date was prior to the start of the survey and was therefore Past Noncompliance. 3.1-45(a)(2)	F 323		